		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

Telephone Number: (217) 356-5164 **Fax #** (217) 356-7873

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas, Partner
(Firm Name & Address) Thomas Healthcare Consulting, P.C., 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038
(Telephone) (317) 577-0101 Fax # (317) 577-3389

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	112	Skilled Pediatric (SNF/PED)	112	40,880	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	39,159	730		39,889	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,159	730		39,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.58%

D. How many bed-hold days during this year were paid by Public Aid? 469 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	205,292	16,721	13,398	235,411		235,411	(88,245)	147,166			1
2	Food Purchase		237,496		237,496		237,496		237,496			2
3	Housekeeping		25,972	112,938	138,910		138,910		138,910			3
4	Laundry	30,795	20,472	88,834	140,101		140,101		140,101			4
5	Heat and Other Utilities			76,029	76,029		76,029		76,029			5
6	Maintenance	45,825	8,705	48,712	103,242	1,128	104,370		104,370			6
7	Other (specify):*											7
8	**TOTAL General Services**	281,912	309,366	339,911	931,189	1,128	932,317	(88,245)	844,072			8
	B. Health Care and Programs											
9	Medical Director			33,600	33,600		33,600		33,600			9
10	Nursing and Medical Records	2,566,209	175,935	36,743	2,778,887	127	2,779,014		2,779,014			10
10a	Therapy	35,970	4,127	111,722	151,819		151,819		151,819			10a
11	Activities	260,183	4,909	294	265,386		265,386		265,386			11
12	Social Services	2,151	1,593	7,166	10,910	(5,766)	5,144		5,144			12
13	Nurse Aide Training	19,624			19,624	320	19,944		19,944			13
14	Program Transportation	6,341	4,986	772	12,099		12,099		12,099			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,890,478	191,550	190,297	3,272,325	(5,319)	3,267,006		3,267,006			16
	C. General Administration											
17	Administrative	55,666		174,268	229,934	(173,348)	56,586	(920)	55,666			17
18	Directors Fees					10,063	10,063		10,063			18
19	Professional Services			429,451	429,451	48,220	477,671		477,671			19
20	Dues, Fees, Subscriptions & Promotions			16,395	16,395	131	16,526	(5,033)	11,493			20
21	Clerical & General Office Expenses	114,018	38,663	32,456	185,137	45,685	230,822	(892)	229,930			21
22	Employee Benefits & Payroll Taxes			700,957	700,957	7,638	708,595		708,595			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,804	12,804	1,773	14,577	(577)	14,000			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,710	46,710		46,710		46,710			26
27	Other (specify):* Bad Debt			8,752	8,752		8,752	(8,752)				27
28	**TOTAL General Administration**	169,684	38,663	1,421,793	1,630,140	(59,838)	1,570,302	(16,174)	1,554,128			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,342,074	539,579	1,952,001	5,833,654	(64,029)	5,769,625	(104,419)	5,665,206			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Swann Special Care Center #0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			184,615	184,615	21	184,636		184,636			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			422,959	422,959	64,224	487,183	(29,204)	457,979			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,950	12,950	(216)	12,734		12,734			35
36	Other (specify):* **Amortization**			38,383	38,383		38,383	(27,835)	10,548			36
37	**TOTAL Ownership**			658,907	658,907	64,029	722,936	(57,039)	665,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			592	592		592		592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			365,056	365,056		365,056		365,056			42
43	Other (specify):* **Edu/Day Training**	878,753	25,460	323,986	1,228,199		1,228,199		1,228,199			43
44	**TOTAL Special Cost Centers**	878,753	25,460	689,634	1,593,847		1,593,847		1,593,847			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,220,827	565,039	3,300,542	8,086,408		8,086,408	(161,458)	7,924,950			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(29,204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(320)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,752)	27		24
25	Fund Raising, Advertising and Promotional	(5,033)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(572)	21		28
29	Other-Attach Schedule	(116,657)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,538)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(920)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (920)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (161,458)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Swann Special Care Center

ID# 0035485

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	School Lunch Program	$ (88,245)	1	1
2	Goodwill Amortization	(27,835)	36	2
3	Non-Allowable Travel	(577)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(116,657)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(88,245)	0	0	0	0	0	0	0	0	0	0	(88,245)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(88,245)	0	0	0	0	0	0	0	0	0	0	(88,245)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(920)	0	0	0	0	0	0	0	0	0	(920)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,033)	0	0	0	0	0	0	0	0	0	0	(5,033)	20
21	Clerical & General Office Expenses	(892)	0	0	0	0	0	0	0	0	0	0	(892)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(577)	0	0	0	0	0	0	0	0	0	0	(577)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,752)	0	0	0	0	0	0	0	0	0	0	(8,752)	27
28	**TOTAL General Administration**	(15,254)	(920)	0	0	0	0	0	0	0	0	0	(16,174)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(103,499)	(920)	0	0	0	0	0	0	0	0	0	(104,419)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Swann Special Care Center** **# 0035485** **Report Period Beginning:** **07/01/02** **Ending:** **06/30/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29,204)	0	0	0	0	0	0	0	0	0	0	(29,204)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(27,835)	0	0	0	0	0	0	0	0	0	0	(27,835)	36
37	**TOTAL Ownership**	(57,039)	0	0	0	0	0	0	0	0	0	0	(57,039)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(160,538)	(920)	0	0	0	0	0	0	0	0	0	(161,458)	45

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Exceptional Care & Training Center	Sterling			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 174,268	Hoosier Care, Inc.	100.00%	$ 173,348	$ (920)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 174,268			$ 173,348	$ * (920)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,518			Director Fees	$ 2,013	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,518			Director Fees	2,013	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,518			Director Fees	2,013	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,518			Director Fees	2,012	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,519			Director Fees	2,012	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,063		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, KY 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing / Medical Records	Revenue	39,559,967	8	$ 600	$ 0	8,353,904	$ 127	1
2	18	Director's Fees	Revenue	39,559,967	8	47,654	0	8,353,904	10,063	2
3	19	Professional Fees	Revenue	39,559,967	8	228,347	0	8,353,904	48,220	3
4	20	Fees,Subscription & Promotion	Revenue	39,559,967	8	622	0	8,353,904	131	4
5	21	Clerical & General Office Exp.	Revenue	39,559,967	8	194,869	0	8,353,904	41,151	5
6	22	Emp. Benefits & Payroll Tax	Revenue	39,559,967	8	36,172	0	8,353,904	7,638	6
7	24	Travel & Seminar	Revenue	39,559,967	8	8,397	0	8,353,904	1,773	7
8	30	Depreciation	Revenue	39,559,967	8	99	0	8,353,904	21	8
9	32	Interest Expense	Revenue	39,559,967	8	304,134	0	8,353,904	64,224	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 820,894	$		$ 173,348	25

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	$ 5,710,000	$ 5,540,000	06/01/2034	7.1250	$ 397,278	1
2	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	260,000	240,000	06/01/2019	10.5000	25,681	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										64,224	6
7												7
8												8
9	TOTAL Facility Related						$ 5,970,000	$ 5,780,000			$ 487,183	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,970,000	$ 5,780,000			$ 487,183	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	None	8
	1999		9
	2000		10
	2001		11
	2002		12

Note: The facility became exempt from property taxes starting 01/01/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,257 B. General Construction Type: Exterior Block & Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED	89,603	1989	$ 538,000	1
2					2
3	TOTALS	89,603		$ 538,000	3

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1989	1975	$ 2,592,000	$ 56,275	10-40	$ 56,275	$	$ 1,124,160	4
5	9			1993	319,955	10,665	30	10,665		129,191	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		14,477	7
8											8
	Improvement Type**										
9	Paint & Panels			1989	1,308		3			1,308	9
10	Blinds			1990	384		3			384	10
11	Fire Doors			1990	2,751		10			2,751	11
12	Storm Windows			1991	4,224		10			4,224	12
13	Fire Doors			1991	3,675		10			3,675	13
14	Compressor			1991	1,035		10			1,035	14
15	Carpeting			1991	220		10			220	15
16	Sprinkler & Fire Alarm			1991	695		10			695	16
17	Sprinkler			1992	3,162		10			3,162	17
18	Damper			1992	674		10			674	18
19	Fire Alarm System			1992	1,945		10			1,945	19
20	Water Heater			1992	1,998		7			1,998	20
21	Roofing			1992	3,900	162	10	162		3,900	21
22	Voltage Relay			1993	1,875	91	10	91		1,875	22
23	Sprinkler System			1993	14,460	964	10	964		14,460	23
24	Wall Covering			1993	3,190	266	10	266		3,190	24
25	Wall Papering			1993	3,000	275	10	275		3,000	25
26	Blinds with Valance			1993	2,395	236	10	236		2,395	26
27	Carpet and Rubber Base			1993	2,848	284	10	284		2,848	27
28	Replace Siding			1993	575	57	10	57		567	28
29	Remodeling in Team Rooms			1993	9,405	941	10	941		9,174	29
30	Plexiglas for Doors & Walls			1993	714	71	10	71		693	30
31	Resurface Parking Lot			1993	19,115	1,911	10	1,911		18,474	31
32	Shed			1993	5,990	599	10	599		5,940	32
33	Stain New Shed			1993	1,248	125	10	125		1,229	33
34	Fire Doors, Closets, Tile			1993	5,225	522	10	522		5,047	34
35	Architectural Renovation			1993	855	85	10	85		816	35
36	Install Alarm & Nurse Call			1994	688	69	10	69		643	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heat Pump	1994	$ 2,017	$ 202	10	$ 202	$	$ 1,851	37
38	Paving for New Sign	1994	680	68	10	68		618	38
39	Labor for Laying Brick - Sign	1994	1,000	100	10	100		908	39
40	Sign for Dedication	1994	325	32	10	32		292	40
41	Sign and Granite Pieces	1994	1,300	130	10	130		1,181	41
42	Material for Leasehold Improvements	1995	7,858		3			7,858	42
43	Hoods, Fans, Ansul System	1995	2,500	250	10	250		2,083	43
44	Work for Exhaust Fan & Hood	1995	3,995	399	10	399		3,292	44
45	Day Room Addition	1995	3,337	334	10	334		2,700	45
46	Replace Water Heater	1995	3,750	375	10	375		3,031	46
47	Day Room Additional Supplies	1995	1,926	193	10	193		1,560	47
48	Walk-in-Cooler	1995	3,334	333	10	333		2,581	48
49	Nurse Call System	1996	1,198	120	10	120		880	49
50	Shed	1996	2,034	203	10	203		1,472	50
51	Air Conditioner Compressor	1996	1,208	121	10	121		857	51
52	Supplies for Leasehold Improvements	1996	3,091		3			3,091	52
53	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose								53
54	Activity Room & Bathroom Addition plus renovation								54
55	to the Dental Office	1996	180,928	9,046	20	9,046		65,584	55
56	Construct Screens, Wheelchairs	1996	1,420		3			1,420	56
57	Construct Shelving, Beds, Screen	1996	2,964		3			2,964	57
58	Install Nurse Call System	1996	1,530	153	10	153		1,071	58
59	Tile Flooring & Adhesive	1996	1,227	123	10	123		840	59
60	Linoleum Flooring	1996	686	69	10	69		460	60
61	Install New Drain Pipes	1996	2,190	219	10	219		1,460	61
62	Remove Concrete to Replace Drain Pipes	1996	575	58	10	58		386	62
63	Install Exit Door Hardware	1997	874	87	10	87		558	63
64	Day Training Improvement	1997	4,078		4			4,078	64
65	Install New Disposal	1997	1,069	107	10	107		615	65
66	Replace Four-Door Glass	1998	520	52	10	52		277	66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		2,151	67
68	Remodel Project 2410 Springfield	1998	33,764	3,517	4	3,517		33,764	68
69	Partition Wall Kitchen / Dinning Area	1998	595	74	8	74		339	69
70	TOTAL (lines 4 thru 69)		$ 3,448,638	$ 95,688		$ 95,688	$	$ 1,514,372	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,448,638	$ 95,688		$ 95,688	$	$ 1,514,372	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	1,765	10	1,765		8,090	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	74	10	74		339	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	1,526	10	1,526		6,994	4
5	Security Door and Hardware - Converted Rooms	1999	520	52	10	52		230	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	300	10	300		1,250	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	116	10	116		493	7
8	Electrical Service Move Switches	1999	141	18	8	18		79	8
9	Installation of Water Heaters	1999	595	60	10	60		250	9
10	Resurface Parking Lot	1999	2,350	157	15	157		615	10
11	14 Almond FRP Panel Dividers	1999	513	103	5	103		403	11
12	Install Alarm System	2000	2,000	400	5	400		1,233	12
13	Install Alarm System	2000	2,730	546	5	546		1,684	13
14	Replaced Compressor on Freezer	1999	635	63	10	63		242	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		153	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		1,043	16
17	Storage Barn	1999	120	5	25	5		19	17
18	Storage Barn	1999	1,045	42	25	42		157	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		573	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		220	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		753	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		2,517	22
23	Intstall Clinical Sink	2000	3,030	606	5	606		1,818	23
24	Stoneybrook Remodeling PR	2000	138,235	27,647	5	27,647		76,029	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		807	25
26	Replace Gate Valve	2000	6,005	400	15	400		1,134	26
27	Replace Ceiling Tile	2000	674	67	10	67		190	27
28	Materials to Tile Bathroom	2001	784	78	10	78		202	28
29	Install Booster Pump	2001	1,995	133	15	133		332	29
30	Install Tile in Bathroom	2001	825	55	15	55		137	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		530	31
32	Replace Reversing Valve	2001	599	60	10	60		130	32
33	Replacement Parts for Roof	2001	662	66	10	66		143	33
34	TOTAL (lines 1 thru 33)		$ 3,679,880	$ 132,012		$ 132,012	$	$ 1,623,161	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,679,880	$ 132,012		$ 132,012	$	$ 1,623,161	1
2	Tile for Bathroom	2001	1,854	185	10	185		385	2
3	Stoneybrook Awning	2001	15,560	3,112	5	3,112		7,780	3
4	Stoneybrook Telephone System	2001	1,668	334	5	334		835	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431	486	5	486		1,215	5
6	Stoneybrook Shelves - Inst	2001	516	103	5	103		249	6
7	Remodeling	2001	8,351	1,670	5	1,670		3,062	7
8	Sprinkler System Renovation	2001	760	51	15	51		102	8
9	Install Shower Drains	2001	10,500	525	20	525		1,050	9
10	Tile to Repalce Tubs	2001	1,278	85	15	85		170	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	140	10	140		269	11
12	Replace Laundry Panel	2001	1,179	79	15	79		138	12
13	Valve-Water Heater	2001	876	88	10	88		154	13
14	Internet Set-up Wiring Cable	2002	6,141	409	15	409		580	14
15	Thermostats with Locking Guards	2002	1,371	91	15	91		106	15
16	Classroom Remodel	2002	5,978	598	10	598		797	16
17	Replace Fencing Around Dumpster Area	2002	674	67	10	67		78	17
18	Replace Doors	2002	3,000	600	5	600		900	18
19	Security System	2002	3,165	633	5	633		897	19
20	Remodeling	2002	8,351	1,670	5	1,670		2,227	20
21	Electrical Labor-Remodeling	2002	1,425	285	5	285		380	21
22	Install Two Sinks	2002	3,561	712	5	712		831	22
23	Revise Sprinkler System	2002	501	100	5	100		125	23
24	Re-seal & Re-stripe Parking Lot	2002	2,810	281	10	281		281	24
25	Install New Phone System	2002	2,735	410	5	410		410	25
26	Install New Phone System / Day Training	2002	2,488	373	5	373		373	26
27	Carpet & Installation	2002	2,954	295	10	295		295	27
28	New Mother Board / Alarm System	2002	1,490	137	10	137		137	28
29	Install A/C Rooftop Unit	2002	8,237	503	15	503		503	29
30	New 2nd Rooftop Compressor	2002	762	42	15	42		42	30
31	Height Adjustment Supine Tub	2002	8,469	494	10	494		494	31
32	Relief Valves / Booster Heater	2003	555	28	10	28		28	32
33	Central Heat / Air Rooftop	2003	5,180	173	15	173		173	33
34	TOTAL (lines 1 thru 33)		$ 3,796,104	$ 146,771		$ 146,771	$	$ 1,648,227	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,796,104	$ 146,771		$ 146,771	$	$ 1,648,227	1
2	New Tile and Base Floor	2003	847	42	10	42		42	2
3	New Hydrotherapy Tub	2003	1,900	95	10	95		95	3
4	Electric Water Heater	2003	5,600	187	10	187		187	4
5	Exhaust Fan	2003	525	4	10	4		4	5
6	Remodeling	2003	8,351	835	5	835		835	6
7			2	9		9		2	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,813,329	$ 147,943		$ 147,943	$	$ 1,649,392	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 140,327	$ 23,242	$ 23,242	$		$ 79,618	71
72	Current Year Purchases	28,766	2,529	2,529			2,529	72
73	Fully Depreciated Assets	469,087	1,436	1,436			469,087	73
74	Corporate Allocation		21	21				74
75	TOTALS	$ 638,180	$ 27,228	$ 27,228	$		$ 551,234	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 GMC Bus	1993	$ 16,250	$	$	$	3	$ 16,250	76
77	Patient Transportation	1985 GMC Bus	N/A	4,041				5	4,041	77
78	Patient Transportation	1989 Ford Mini Bus	1998	3,000	600	600		5	2,850	78
79	See Attached			45,214	8,865	8,865		5	22,156	79
80	TOTALS			$ 68,505	$ 9,465	$ 9,465	$		$ 45,297	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,058,014	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,636	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,636	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,245,923	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Classroom conversion to	$ 15,336	92
93	patient rooms.		93
94			94
95		$ 15,336	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,734 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		5,322		5,322
4	Clinical Wages	(b)		10,644		10,644
5	In-House Trainer Wages	(c)		3,658	320	3,978
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 19,624	$ 320	$ 19,944
10	SUM OF line 9, col. 1 and 2	(e)	$ 19,624			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,309	$	1
2	Cash-Patient Deposits	99,864		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (20,400))	1,499,875		3
4	Supply Inventory (priced at Cost)	38,988		4
5	Short-Term Investments			5
6	Prepaid Insurance	(43,738)		6
7	Other Prepaid Expenses	19,365		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to / from Corporate	(5,133,044)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,483,381)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	3,813,329		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	706,685		16
17	Accumulated Depreciation (book methods)	(2,245,923)		17
18	Deferred Charges	326,977		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,422		21
22	Other Long-Term Assets (specify):	547,201		22
23	Other(specify): Goodwill	726,040		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,414,731	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 931,350	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 81,854	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	99,864		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,587		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,861		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	34,994		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 410,160	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,780,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,780,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,190,160	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,258,810)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 931,350	$	48

***(See instructions.)**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,555,510)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,555,510)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	296,700	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 296,700	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,258,810)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,407,844	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,407,844	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	614	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 614	8
	C. Other Operating Revenue		
9	Payments for Education	893,465	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 893,465	23
	D. Non-Operating Revenue		
24	Contributions	40,101	24
25	Interest and Other Investment Income***	29,204	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69,305	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	923,635	28
28a	School Lunch Program	88,245	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,011,880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,383,108	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	931,189	31
32	Health Care	3,272,325	32
33	General Administration	1,630,140	33
	B. Capital Expense		
34	Ownership	658,907	34
	C. Ancillary Expense		
35	Special Cost Centers	1,228,791	35
36	Provider Participation Fee	365,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,086,408	40
41	**Income before Income Taxes (line 30 minus line 40)****	296,700	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 296,700	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,208	2,325	$ 53,999	$ 23.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,847	28,064	567,549	20.22	3
4	Licensed Practical Nurses	11,717	12,480	215,181	17.24	4
5	Nurse Aides & Orderlies	137,231	149,770	1,729,480	11.55	5
6	Nurse Aide Trainees	2,040	2,040	19,624	9.62	6
7	Licensed Therapist	1,631	1,760	35,970	20.44	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,941	2,086	30,645	14.69	9
10	Activity Assistants	24,840	25,767	229,538	8.91	10
11	Social Service Workers	47	47	2,151	45.77	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,102	37,095	17.65	13
14	Head Cook	8,303	8,887	110,081	12.39	14
15	Cook Helpers/Assistants	2,487	2,654	28,999	10.93	15
16	Dishwashers	2,188	2,364	29,117	12.32	16
17	Maintenance Workers	3,650	4,006	45,825	11.44	17
18	Housekeepers					18
19	Laundry	2,065	2,301	30,795	13.38	19
20	Administrator	2,007	2,063	55,666	26.98	20
21	Assistant Administrator					21
22	Other Administrative	553	601	6,341	10.55	22
23	Office Manager					23
24	Clerical	5,838	6,288	114,018	18.13	24
25	Vocational Instruction					25
26	Academic Instruction	24,942	27,466	359,777	13.10	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,912	1,981	23,284	11.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	38,386	40,318	495,692	12.29	33
34	TOTAL (lines 1 - 33)	301,740	325,370	$ 4,220,827 *	$ 12.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	400	$ 13,398	1.3	35
36	Medical Director	448	33,600	9.3	36
37	Medical Records Consultant	4	300	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	600	10.3	39
40	Physical Therapy Consultant			10a.3	40
41	Occupational Therapy Consultant	889	48,498	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,059	58,245	10a.3	43
44	Activity Consultant	7	260	11.3	44
45	Social Service Consultant	28	1,400	12.3	45
46	Other(specify) Dental Fees	N/A	3,865	10.3	46
47	Utilization Review				47
48	See Attached	22,968	263,637		48
49	TOTAL (lines 35 - 48)	25,803	$ 423,803		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	740	31,608	10.3	52
53	TOTAL (lines 50 - 52)	740	$ 31,608		53

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Lou Bedient	Administrator	0	$ 55,666
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,666

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 174,268
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,268
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation		$
Centers, Inc.	Management Fees	426,000
Thomas Healthcare Consulting	Accounting Fees	3,600
Other Fees	Other	(149)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 429,451

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,873
Unemployment Compensation Insurance	44,047
FICA Taxes	319,642
Employee Health Insurance	263,613
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	24,782
Corporate Allocation	7,638
TOTAL (agree to Schedule V, line 22, col.8)	$ 708,595

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	864
(Indicate # of checks performed 81)	
Illinois Health Care Assoc.	5,507
Council for Exceptional Children	109
Public Relations	9,150
Corporate Allocation	131
Other Fees	365
Less: Public Relations Expense	(5,033)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,493

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 577
Non-Allowable Out-of-State	(577)
In-State Travel	7,659
Seminar Expense	4,568
Corporate Allocation	1,773
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,000

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,989** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **365,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **88,245**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **31,586**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Resnick, Fedder, & Silverman** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.